COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

SARA REDDING WILSON
DIRECTOR

James Monroe Building
101 N. 14th Street
Richmond, Virginia 23219

To: State Retiree Health Benefits Program Participants Not Eligible for Medicare

From: Charles Reed, Associate Director
State and Local Health Benefits Programs

Date: April 4, 2003

Re:
- Your Monthly Premium Rates and Plan Choices Effective July 1, 2003
- Retiree Group Updates

Open Enrollment: Another year has passed, and it is again time for your annual Open Enrollment under the State Retiree Health Benefits Program. This year, Open Enrollment is from **April 15 through May 16**, during which you can make your annual health plan election for July 1. July 1 will bring some changes to your coverage options, so please take a few moments to read the enclosed materials thoroughly so that you can make an informed decision about your health plan coverage. When you have made your coverage decision, be sure to submit your enrollment form in time for it to be **received no later than May 16, 2003**, by the addressee noted on the front of the form (or you may use EmployeeDirect on line at http://edirect.state.va.us).

New Plan Choices: Effective July 1, both the Key Advantage and Cost Alliance Plans will be discontinued. They will be replaced by a new plan, COVA Care, which includes all of the same benefits previously covered under Key Advantage and Cost Alliance Plans, but with some changes in benefits structure.

COVA Care consists of a basic plan and three additional plan options which can be elected individually, combined, or declined so that participants can design a plan that works for their individual health care needs. The monthly premium for COVA Care coverage will be good news for most retiree group participants since the cost for COVA Care basic coverage is actually a few dollars less per month than the current premium for both Key Advantage at all membership levels and Cost Alliance at the "two-person" membership level. There is also a significant premium savings for the few retiree group participants who are in Cost Alliance single coverage. Unfortunately, a very small number of retiree group members who are currently in Cost Alliance family membership will see a substantial premium increase. Please refer to the enclosed *Health Benefit Plans for the Non-Medicare Retiree Group* brochure for monthly premiums.

Participants in Northern Virginia who are in the Kaiser Permanente HMO service area may still elect or continue coverage in that plan. New monthly premiums and a benefits summary for the Kaiser plan may be found in the enclosed *Health Benefit Plans for the Non-Medicare Retiree Group* brochure.

With the exception of current Kaiser Permanente members, all participants who take no action during the Open Enrollment period will be placed in the COVA Care basic plan (no additional options) at their existing membership level. Current Kaiser Permanente members who take no enrollment action will continue in the Kaiser plan with their existing membership level on July 1.

Premiums: July 1 premium rates are listed in the enclosed *Health Benefit Plans for the Non-Medicare Retiree Group* brochure.

Health Insurance Credit (HIC) benefits will not change for participants who are eligible for the HIC Program, which is administered by the Virginia Retirement System.

COVA Care Highlights: Some of the main features of the new COVA Care Plan include:

- Participants will no longer be required to select a primary care physician (PCP) or obtain a referral to see a specialist. However, if you see a participating general practitioner, family practice physician, internist or pediatrician, you will pay the PCP copayment ($25); if you see any other specialty physician, your copayment will be $35. This will be applicable to all participants, regardless of their location, so out-of-state retiree group members will now have the benefit of a lower PCP copayment.
- The network of participating providers will now include the national and worldwide BlueCard PPO network. No matter where you travel or live, you may contact BlueCard Access at 1-800-810-BLUE, and obtain access to a participating medical* provider. Your benefit will be consistent with all other plan participants, regardless of your location. If you use a BlueCard PPO provider, you will not have to file any claims, and you will not be responsible for any balance billing greater than your designated copayment or coinsurance level. Since 85% of all hospitals and physicians in the U.S. participate with the BlueCard PPO network, and there are networks in every state, you have extensive access to in-network care and protection from additional billing.
  *You are not required to use a participating dental provider. Your dental benefit will always be at the allowable charge level for the Anthem plan.
- Under the basic plan, there will be no coverage for using out-of-network providers except in an emergency. However, an optional out-of-network benefit is available if you wish to maintain the choice of using providers outside the Anthem, BlueCard PPO or Magellan networks. Please see the enclosed *Health Benefit Plans for the Non-Medicare Retiree Group* brochure for more information on this optional benefit.
- COVA Care provides an annual benefit for a wellness check-up. See the enclosed *Health Benefit Plans for the Non-Medicare Retiree Group* brochure for more information.
- The COVA Care prescription drug benefit will be based on a three-tier program. Please be sure to read the enclosed *"Open Forum"* newsletter for more information about your new prescription drug benefit.
- While primary dental benefits are covered under the basic COVA Care Plan, you may purchase an optional Expanded Dental Benefit. Also available is a combined Vision, Hearing and Expanded Dental Benefit option. See the enclosed *Health Benefit Plans for the Non-Medicare Retiree Group* brochure for more information.
- Your mental health and substance abuse benefits under the COVA Care Plan are administered by Magellan Behavioral Health. To access these benefits or ask questions relating to the plan, call Magellan at 1-800-775-5138.

Two Carriers Leave the Program: Effective July 1, 2003, Aetna U.S. Healthcare (HMO and POS) and the Piedmont Community Healthcare Plan will cease to be options under the state program. Current participants in those plans may choose the COVA Care plan and any of its additional options for coverage beginning July 1. If no action is taken, current Aetna and Piedmont members will default to the COVA Care basic plan (no additional options).

How to Make Plan/Membership Changes: To make a plan and/or membership election, please submit your enrollment form (enclosed) to the address noted on page one of the form no later than May 16, 2003 (the form must be **received** by that date). With the exception of current Kaiser Permanente members, all participants who fail to make an election during the Open Enrollment period will be placed in the COVA Care basic plan (no additional coverage options) effective July 1, with no change in membership level. (Participants may also make changes using the *Employee Direct* system on the Web.) Monthly premiums will be adjusted accordingly.

Remember—Open Enrollment provides an opportunity to make changes to your plan and membership level without a qualifying mid-year event. At the conclusion of the Open Enrollment period, no other plan changes or membership increases can be made during the plan year unless there is a consistent qualifying mid-year event that would allow that change.

New Anthem ID Cards: All participants will receive new identification cards by July 1, 2003. All new cards, with the exception of those generated to Kaiser Permanente members, will reflect a new format that identifies the COVA Care plan and its access to the BlueCard PPO network. In addition, all Anthem plan cards will reflect the new Anthem Blue Cross and Blue Shield logo. As many of you know, Trigon Blue Cross Blue Shield is now part of Anthem, Inc., and on December 2, 2002, changed its name to Anthem Blue Cross and Blue Shield.

For additional information on Anthem plan benefits or claims, please contact Anthem Member Services or visit the Anthem Web site. See the "Plan Contact Summary" on page 5 for contact information.

Member Handbooks: All COVA Care participants will receive a new Member Handbook by July 1. We hope that you find the new handbook format to be an excellent resource.

Meetings: All non-Medicare-eligible State Retiree Health Benefits Program participants received a postcard in March that provided meeting opportunities so that they could learn more about options available during this Open Enrollment period. We were pleased to be able to include retiree group members in these valuable informational sessions and regret that, due to budget and time constraints, meeting locations were not convenient to all participants. However, we hope that those who attended found these meetings to be useful. Let us know what you think about these meetings. Send your comments by e-mail to hbp@dhrm.state.va.us.

Due to security issues, we were unable to arrange for retirees to attend the video broadcasts held on April 7.

Plan Contact Information: You may obtain additional information about your health plan options by contacting the plan administrator directly. A summary of plan contact information is on page 5.

Dependent Eligibility: There has been a change in eligibility criteria for dependent children to be covered under the State Retiree Health Benefits Program. Any biological or adopted child may be covered until the end of the year in which he or she turns age 23, provided the child is unmarried, lives at home (except in cases when a child lives with the other parent if the employee is divorced, or in cases where the child lives away from home while attending college or boarding school), and is eligible to be claimed on the participating parent's federal income tax return. Participants who have a child who is newly eligible for coverage may add him or her during Open Enrollment. Any dependents who are no longer eligible for coverage based on these new criteria must be removed by July 1, 2003. Maintaining coverage for an ineligible dependent can result in suspension from the program.

Medicare Eligible Participants Under Age 65: When an enrollee (retiree, survivor, VSDP/LTD participant) or his/her covered dependent becomes eligible for Medicare before reaching age 65 (the normal Medicare eligibility age), an enrollment form must be submitted immediately to indicate a Medicare-coordinating plan selection. It is the responsibility of the enrollee to ensure adherence to this provision. **Failure to do so could result in significant coverage deficits.**

This is an important provision of the State Retiree Health Benefits Program. Medicare becomes the primary payer of claims immediately upon the participant's **eligibility** for Medicare coverage, so all Medicare-eligible participants **must** enroll in both Parts A and B in order to get the full benefit of any state Medicare supplemental coverage. If it is determined that a participant is eligible for Medicare but has not enrolled in a Medicare-coordinating plan, he or she will be placed in a Medicare-coordinating plan immediately, and primary claim payments made in error may be retracted. If participants have declined Medicare Part B coverage, it could also result in a delay in Part B enrollment and, as a result, a gap in coverage until Part B goes into effect.

Retiree Group Members Becoming Eligible for Medicare During the Open Enrollment Period: Approximately three months before their 65th birthday, all retiree group members, including covered dependents, receive information about options for selecting a Medicare-coordinating plan. At that time, if an election is not made, Medicare-eligible members are placed in the Advantage 65 Plan. This process continues during the Open Enrollment period, so some members will receive both a Medicare plan enrollment package and an Open Enrollment package. If you become eligible for Medicare prior to July 1, your Medicare plan election will supersede any Open Enrollment election. If you become eligible for Medicare after July, you may make an Open Enrollment election for July 1, and your Medicare plan election will take place on the first of the appropriate month after July.

Direct Billing of Premiums: For some retirees, an increased premium will mean that the amount of your monthly retirement annuity will no longer be sufficient to cover your monthly premium amount. In those cases, you will begin to be billed directly by Anthem (or Kaiser Permanente if appropriate). Keep in mind that, due to administrative differences, direct billing occurs in advance of the coverage month, while annuity-deducted premiums are collected in arrears.

Prompt Payment of Premiums: Plan participants are responsible for paying their premiums (either through annuity deduction or by direct payment to the carrier) in the time frame required. Participants who pay directly to the carrier receive monthly bills which specifically indicate when premium payments are due. Monthly premiums that remain unpaid for 31 days after the due date will result in termination of coverage.

Participants are responsible for understanding their premium obligation and notifying the program within 31 days of any qualifying mid-year event that affects membership level. Premiums which are incorrect due to failure of the participant to advise the program of membership reductions may result in loss of premium overpayments. Failure of the participant to remove ineligible dependents may result in retraction of claim payments and suspension from the program.

Health Insurance Portability and Accountability Act Privacy Notice: Please be sure to review the enclosed *Employee/Retiree Privacy Notice* that explains how medical information about you may be used and disclosed and how you can get access to this information based on the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In addition, enclosed is a notification of changes to your **current** plan's member handbook which reflects HIPAA provisions effective on April 14, 2003. Please keep this information with your member handbook until July 1 when your new handbook will take effect.

Newsletter: Please take a moment to read the enclosed "*Open Forum"* newsletter, which contains more important information about the new COVA Care Plan.

Also Inside:

Enclosures:

- *Health Benefit Plans for the Non-Medicare Retiree Group* brochure
- Enrollment Form
- *"Open Forum"* Newsletter
- Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice
- **Current** Member Handbook Notification of Changes

Plan Contact Summary

COVA Care Plan	***Call or Visit the Web Site***
Anthem Blue Cross and Blue Shield – Medical Services for COVA Care	**Member Services:** **(804) 355-8506 in Richmond** **1-800-552-2682 outside of Richmond** **www.anthem.com** * *Once at the site, select "Members & Consumers," then choose "Virginia." On that page, you will find a link to the dedicated Commonwealth of Virginia site.
Magellan Behavioral Health – Mental Health & Substance Abuse Services for COVA Care	1-800-775-5138 TDD 1-800-828-1120 Virginia Relay Center **www.magellanassist.com**
Regional Plan	***Call or Visit the Web Site***
Kaiser Foundation Health Plans (available in Northern Virginia only)	**Member Services:** **1-301-468-6000 or 1-800-777-7902** **Dental Services:** **1-800-445-9090** **www.kp.org/ehealth/mida/commonwealthofvirginia**

Notice

Women's Health and Cancer Rights

In the case of a participant who is receiving benefits under the state's health benefits plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications during all stages of the mastectomy

STATE RETIREE HEALTH BENEFITS PROGRAM – A CLOSER LOOK AT COVA CARE
A Comparison of the New COVA Care Plan and Current Statewide Plans

	New COVA Care (basic plan)	Current Key Advantage (basic plan)	Current Cost Alliance (basic plan)
How the Plans Work	***Effective 7/1/2003***	***No Longer Available After 6/30/2003***	
Primary Care Physician Required	No	Yes	Yes
Specialist Referral Required	No	Yes	Yes
Provider Network	- Blue Cross PPO network worldwide, including current Anthem providers and others in all 50 states - Magellan national network for mental health and substance abuse services.	- Anthem's PPO hospital and professional provider network - Magellan national network for mental health and substance abuse services.	- Anthem's PPO hospital and professional provider network - Magellan national network for mental health and substance abuse services.
Coverage Outside Network	- No coverage except for life-threatening emergency - Optional Out-of-Network benefit provides coverage at 25% reduction for non-network services	Coverage at 25% reduction for non-network services	No coverage outside network except for life-threatening emergency
Annual Deductible	Applies to certain services requiring coinsurance: diagnostic tests, lab, x-rays, shots, medical supplies and equipment, ambulance, private duty nursing $200 per member, no more than $400 per family	Applies to medical supplies and equipment, ambulance, private duty nursing $100 per member, to $300 per family	None
Coinsurance	10% - diagnostic tests, lab, x-rays, shots 20% - medical supplies and equipment, ambulance, private duty nursing	10% - diagnostic tests, lab, x-rays, shots 20% - medical supplies and equipment, ambulance, private duty nursing	None
Annual Out-of-Pocket Limit	Medical and mental health deductible, copayments and coinsurance apply $1500 per member, no more than $3000 per family	Medical and mental health deductible, copayments and coinsurance apply $1000 per member, no more than $3000 per family	Medical and mental health copayments apply $2500 per member
Maximum Lifetime Benefit	$1,500,000	$1,000,000	$1,000,000
Comparison of Benefits			
COPAYMENTS PCP Office Visit (PCP is a general or family practitioner, internist or pediatrician)	$25 (PCP designation not required)	$20 (must designate PCP)	$20 (must designate PCP)
Specialist Office Visit (medical or mental health/substance abuse)	$35 (referral not required)	$30 (referral required)	$35 (referral required)
Inpatient Facility (medical or mental health/substance abuse)	$300 per stay	$300 per stay	$100 per day up to $500 per admission
Outpatient Facility (medical or mental health/substance abuse, including ER)	$100 per visit	$100 per visit	$75 per visit
WELLNESS AND PREVENTIVE SERVICES Well Child Care (under age 7) - Office Visits - Immunizations - Preventive Screenings and Tests	Deductible does not apply to wellness or preventive care $25 per PCP or $35 per specialist visit - $0 - 10% coinsurance	 - $20 per PCP or $30 per specialist visit - $0 - 10% coinsurance	 - $20 per PCP or $35 per specialist visit - $0 - $0
Wellness Care - Well man or woman care (annual GYN or prostate exam) - Mammogram, Pap or PSA - Annual Check-up (age 7 and above)	- $25 per PCP or $35 per specialist visit - 10% coinsurance - $25 per PCP or $35 per specialist visit; 10% coinsurance - lab, preventive screenings, immunizations ($200 benefit per member per year)	- $20 per PCP or $30 per specialist visit - 10% coinsurance - Not Covered	- $20 per PCP or $35 per specialist - $0 - $0

	New COVA Care (basic plan)	Current Key Advantage (basic plan)	Current Cost Alliance (basic plan)
OTHER BENEFITS Employee Assistance Visits	Up to four counseling sessions free of charge	Up to four counseling sessions free of charge	Up to four counseling sessions free to charge
Diagnostic Tests, Lab and X-Ray	10% coinsurance after deductible	10% coinsurance	$0 physician's office; $35 lab or outpatient hospital
Other Covered Services (medical supplies and equipment, ambulance, private duty nursing)	20% coinsurance after deductible	20% coinsurance after deductible	$0 ($1000 annual max, prostheses, medical equipment and supplies); private duty nursing, orthopedic devices not covered
Spinal Manipulations and Other Manual Medical Interventions	$25 per PCP or $35 per specialist visit (includes chiropractic services); $500 benefit per member per year	$20 per PCP or $30 per specialist visit (includes chiropractic services); $500 benefit per member per year	Not covered
PRESCRIPTION DRUGS Retail Pharmacy	Up to 34 day supply $15 – Tier 1 (generally generics) $20 – Tier 2 (generally mid-cost brands) $35 – Tier 3 (generally higher cost brands)	$17 – up to 34 day supply $34 – 34 to 90 day supply	$20 – up to 34 day supply $40 – 34 to 90 day supply
Home Delivery (Mail Service)	Up to 90 day supply $30 – Tier 1 (generally generics) $40 – Tier 2 (generally mid-cost brands) $70– Tier 3 (generally higher cost brands)	$25 – up to 90 day supply	$28 – up to 90 day supply
DENTAL BENEFITS	Diagnostic, preventive and primary services ($1,200 per member annual benefit)	Diagnostic, preventive and primary services ($1,200 per member annual benefit)	Not covered
OPTIONAL BENEFITS (available at additional cost) Out-of-Network Coverage	Optional coverage for providers outside Magellan, Anthem or BC/BS PPO networks at 25% reduction for non-network services	Included in Key Advantage basic plan	Not available
Preventive Care and Immunizations	Covered under COVA Care basic plan	Optional *KA Expanded* covers preventive care tests and screenings, immunizations	Covered under Cost Alliance basic plan
Dental Benefits	- Diagnostic, preventive and primary covered under COVA Care basic plan - Optional *Expanded Dental* covers orthodontic ($1,200 lifetime max) and complex restorative - $1,500 per member annual benefit for basic and expanded dental services	- Diagnostic, preventive and primary covered under KA basic plan - Optional *KA Expanded* covers orthodontic ($1,200 lifetime max) and complex restorative - $1,200 per member annual benefit for basic and expanded dental services	Optional *CA with Dental* covers diagnostic and preventive, primary, and complex restorative ($1,200 per member annual benefit); and orthodontic ($1,200 lifetime max)
Vision Benefits	Available under *Vision, Hearing and Expanded Dental* Covers vision exam, frames, lenses or contact lenses every 24 months	Available under *KA Expanded* Covers vision exam, frames, lenses or contact lenses every 24 months	Not available
Hearing Benefits	Available under *Vision, Hearing and Expanded Dental* Covers hearing exam ($35 copayment) and one hearing aid per impaired ear every 48 months ($1,200 per member benefit every 48 months)	Not available	Not available